

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 011437	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/12/2013
NAME OF PROVIDER OR SUPPLIER COMMUNITY HOSPITAL NORTH		STREET ADDRESS, CITY, STATE, ZIP CODE 7150 CLEARVISTA DR INDIANAPOLIS, IN 46256		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>INITIAL COMMENTS</p> <p>This visit was for the investigation of a licensure complaint.</p> <p>Survey Type: Licensure complaint IN00118342 Unsubstantiated, lack of sufficient evidence.</p> <p>Date of Survey: 07-12-13</p> <p>Facility number: 011437</p> <p>Surveyors: John Lee, R.N. Public Health Nurse Surveyor</p> <p>Community Hospital North is in compliance with 410 IAC 15-1.5-4, Medical record services, and 410 IAC 15-1.5-6, Nursing service, Hospital Licensure Rules.</p> <p>QA: cloughlin 07/17/13</p>	S 000		

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TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

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If continuation sheet 1 of 1